

A-3 STANFORD UNIVERSITY MEDICAL CENTER (BEST PRACTICES)



Establishment of a Smallpox or Infectious Disease Isolation Unit at Stanford Hospital and Clinics / Lucile Packard Children's Hospital¹

April 7, 2003

Updated 29 January 2006

- A. The goal of the Small Pox or infectious disease isolation unit is to protect staff and patients by establishing a secure versatile treatment area at Stanford University Medical Center (SUMC) to screen visitors, staff and patients for Small Pox or other diseases, and provide safe limited inpatient care for patients with a highly contagious disease such as Small Pox, Influenza or other similar disease.
 1. Stanford Hospital and Clinics and Lucile Packard Children's Hospital intend to maintain a capability to screen for and room patients with highly infectious communicable diseases and prevent the spread of the disease to the rest of the hospital population. It is not SUMC's intent to become the regional care facility for such patients, but rather to have a capability to care for the patients that present themselves to SHC or LPCH.
 2. Safety for the staff, patients, and general public is paramount. This is why the location of East Pavilion (G&H-1 and G&H-2) was chosen. This building is the easiest to isolate and provides good proximity to the Emergency Department while being the furthest away from other inpatient care units. Unit B-1 may be used as an additional or overflow unit if needed.
 3. In the event that this plan is implemented the patients of G&H-1, G&H-2 nursing units may have to be moved. Additionally, the third floor GYN and Peds offices and the ground floor offices may have to be moved or shut down as well. Since there is no other suitable location for a locked psychiatric unit at SUMC, that operation may need to be closed and the patient population moved to another facility. Other patients will need to be integrated on existing nursing units. Additionally the financial loss of income from the closed nursing units, the need to reconfigure the physical plant, and the man hours that will be needed to implement, manage and operate the unit maybe great. Many of the services may not be billable. It is therefore advised to consider these issues prior to implementing this plan.
 4. The SHC Chief Executive Officer, Chief Operating Officer and Administrator on call for Stanford Hospital & Clinics have authority to enact this plan. If the patients are pediatric, LPCH should request authority from SHC to establish this Unit. Activation of this plan constitutes Disaster Plan activation and notifications will be made to local, county, state and federal authorities. This is an important feature as it may assist obtaining additional assistance and financial compensation of unrecoverable expenses.
- B. Plan Overview
This plan will be separated into three parts:
 - Code Zebra – Event Investigation and Response Planning
 - Plan Implementation and Operation
 - Event Recovery

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May 2008

C. Code Zebra – Event Investigation and Response Planning

1. A Code Zebra may be activated whenever it is believed that there is a patient at SHC or LPCH that may have a highly contagious disease such as Small Pox, or that there are unusual levels of illness that may be a result of an unusual outbreak, or terrorist attack.
2. Upon deciding that a Code Zebra is needed, the authorized person shall call 211 and state who they are and indicate that they want a Code Zebra activated. Generally, individuals responding to a Code Zebra will report to H3210
3. A Code Triage may be activated as well if the number of patients presenting to the ED warrant a Code Triage Response. Operator services shall complete the Code Zebra first and then call a Code Triage if ordered to do so.
4. The following persons are authorized to call/declare a Code Zebra
 - a. Infectious Disease Attending
 - b. Emergency Department Attending
 - c. Emergency Department Nurse Manager or Resource Nurse
 - d. Chief of Medical Staff
 - e. Administrator on Call
5. The following is an outline of actions that should occur upon a Code Zebra Activation
 - a. Responders meet at the designated location.
 - b. If unable to arrive at designated location, responders may call the indicated phone number on the page and advise the staff of his/her estimated time of arrival.
 - c. The person requesting the Code Zebra gives a complete report to the responders.
 - d. A determination is to be made as to what actions are need, if any, to protect staff and the patient population.
 - e. Senior Hospital Administration is to be notified of any actions.
 - f. Notifications may be necessary to local, state or federal government
6. There is no overhead page required for a Code Zebra.

7. Page Group Zebra Example: Please note that the master copy is maintained by Communications Services:

Admitting LPCH	Hospital Administration LPCH	Nursing Supervisor LPCH
Admitting SHC	Hospital Administration SHC	Occupational Health and Safety
ADMINISTRATOR ON CALL for LPCH	Infection Control LPCH	Operator Services Unit
ADMINISTRATOR ON CALL for SHC	Infection Control SHC	Pharmacy Administration
Clinical Microbiology Director	Infectious Disease Attending	Risk Management
COO LPCH	Infectious Disease Fellow	School of Medicine Health and Safety
COO SHC	Medical Records LPCH	Security Services
ED Medical Director	Medical Records SHC	Selected ED Physicians
Emergency Preparedness Chair	News and Communications LPCH	Stanford University Biosafety Officer
Emergency Preparedness Coord.	News and Communications SHC	Stanford University Incident Commander
Environmental Health and Safety	Nursing Supervisor SHC	

8. Code Activation

- a. Upon advice of the Code Zebra team, the Administrator on Call / Incident Commander may decide to do the following

- Determine that there is no public health emergency and do nothing further
- Wait and collect more information
- Ready the facility for further action to be determined or planned
- Begin immunizing staff / public against suspected disease
- Conduct facility lock down with infectious disease screening
- Begin with establishment of a quarantine unit.
- b. If the ADMINISTRATOR ON CALL decides to: to ready the facility for further action to be determined or planned, begin immunizing staff / public against suspected disease, conduct facility lock down with infectious disease screening, begin with establishment of a quarantine unit, the ADMINISTRATOR ON CALL will have to declare a disaster and implement a Code Alpha. A Code Alpha will assemble the emergency operations staff in the HEOC H3210 or LPCH Board Room and being mobilization for the response action.
- c. At this point, the disaster plan will guide emergency operations center steps.
- d. Activation of ICU Team
- e. Activation of the ICU team would be through Barbara Odin – manager of the ICU. LPCH activation would be through notification of the nursing supervisor.

D. Plan Implementation

1. Immunizations

Stanford and Packard hospitals will begin the immunizations of staff and possibly families as soon as possible.

- a. Staff immunizations as a response to an index case, or actual exposure are to be performed by Occupational Health and Safety and shall follow the model recommended by the Santa Clara County Health Department and CDC. In an emergency, additional staff may need to be added on to accommodate a more rapid vaccination process.
- b. All staff working on the isolation unit, or providing exam or screening services are to be immunized appropriately.

2. Emergency Management and Incident Command

In the event that special procedures are needed to prepare for or control a Small Pox or infectious disease outbreak, the hospital will declare a disaster and implement the Hospital Emergency Management Plan. Only needed components as outlined in the Hospital Emergency Management Plan are to be implemented. The Incident Commander will have authority to direct staff and manage assets as needed to respond to the incident.

LPCH and SHC shall operate jointly in managing this emergency.

3. Inpatient unit set up

- a. Facilities - In the event of a Small Pox or infectious disease outbreak SHC & LPCH will lockdown facilities, and limit entry. All individuals entering the hospital will need to be screened for symptoms of the disease in question. Security will address the lockdown procedure for the buildings, however all staff will act as an extension of the Security Services in order to maintain the integrity of the facility.
- b. Staff will also be needed to direct the flow of people arriving for care to the screening areas. Interpreters and/or staff who speak other languages in addition to English will be needed to translate for screeners, escorts and crowd control.
- c. Screening Sites
 - There are five primary screening sites at SUMC: LPCH main entrance, Boswell Clinic entrance, Emergency Department entrance, Loading Dock and Hoover Pavilion if needed.
 - At offsite patient care facilities such as 770 Welch Road clinics and others, the ventilation system may spread airborne virus through the building, and therefore precautions need to be taken. The options are:

- Perform a building lockdown. Screen all individuals entering the building.
 - Shut down clinical operations at offsite buildings.
 - These options need to be presented to the building Manager or owner for final approval.
- d. Screening Personnel (This plan is in continuing development by the Bioterrorism Taskforce)
- Various Nursing departments as outlined below will provide staff for the screening stations. The number of individuals may vary, but may include RN, LVN and Nursing Aides.
 - Boswell – Clinic Administration 12 persons
 - ED Entrance – SHC Nursing department 12 persons
 - LPCH – LPCH Nursing 12 persons
 - Hoover Pavilion – Clinic Administration 4 person
 - Loading Dock – SHC Nursing Administration 1 person
 - Physicians will support the exam area at the G-H 1 Unit.
 - All screening, exam and treatment personnel must be fitted for N95 mask and immunized for Small Pox or the disease in question.
 - Staff who complete the first set of screening questions do not need to be licensed personnel. The screening procedure does have to be performed by licensed personnel.
 - Screeners need to wear the following:
 - Fitted N95 Masks (Check to ensure that staff has been fitted)
 - Disposable yellow gowns
 - Gloves
- e. Screening Procedure See attached “Small Pox or Infectious Disease Screening Questions and Examination”.
- f. Physical Plant: An outpatient treatment unit, medical research unit, medical psychiatry unit, and locked psychiatry unit currently occupy the location. On the third floor there are offices for the departments of obstetrics and pediatrics and on the ground floor offices for support services departments. The units will need to be moved. The ground and third floor units may stay depending on the assessed risk.
- Location: G/H-1 with further expansion to G/H-2.
 - **TOTAL BEDS ~ 22**
 - Capabilities: The unit will have a screening and exam area on the far end of H-G-1. The demarcation line between the inpatient and screening unit will be the double doors that separate the units into two. This demarcation may be outfitted with a plastic barrier to limit access and airflow. The unit also contains a kitchen area, 2 Nursing stations, offices, conference rooms, and other services.
 - Entrances: The normal entrance to G-H1 will be covered with a temporary construction barrier consisting of steel studs and a single layer of sheet rock. The sheet rock will be scored on the inside for easy emergency access into the Hospital.
 - Fire Exits G101 H101 and H 120 would be designated exits. Emergency exit may also be afforded through the old main entrance to the hospital via scored sheet rock panels.
 - H-1 may use room H117 as a temporary storage room. The Lab on H-1 will be sealed from the main hallway and not used. Staff may enter the lab from the outside hallway once clearance is given by EH&S that the lab is sufficiently sealed to protect its contents and staff from possible exposure.
 - The main entrance to the screening area will consist of the sliding glass doors in the solarium area. One set of sliding doors will be the entrance the other the exit.
 - The main entrance to the isolation unit will be on the G side. This entrance shall consist of a two stage area where staff and materials can be staged and enter the unit. The exit will be on the H side and consist of a three stage decontamination area. The first stage will be for wiping down and staging materials and persons that are to leave the unit. The second stage will consist of a washing/shower area where appropriate soaps and decontamination solutions are applied to the outside of the materials to exit the unit. Persons will shower in this area as directed by infection control. If showering is required by Infection Prevention, then it is mandatory to exit the unit. In addition, there are male and female showering facilities located in room s H101 and H102. Additional exits and entrances can be established from G101, H101 H102 or H117
 - Windows: All windows are to be closed, and the windows to inpatient rooms with infectious patients sealed to prevent air transfer to the outside.

- The ventilation system needs to be isolated so that no air is exhausted from the unit through the hospital ducting system. The ventilation system is to be sealed and blanked off under supervision of Engineering and Maintenance.
 - Negative pressure is to be maintained in each room that may house a patient. Sufficient negative air pressure is to be maintained on each patient room to ensure 12 air changes per hour. Exhausted air is to be evacuated through DOP tested HEPA filters. DOP testing is to take place prior to occupancy.
 - Room pressures are to be checked at least daily or if and recording manometer is available for each room monitoring is to be done continuously.
 - Primary contractor for establishing negative pressure shall be an asbestos abatement contractor. Oversight shall be conducted by an Industrial hygienist who has experience in asbestos abatement.
 - Make-up air to the patient rooms shall come from the main halls. All exhaust vents in main halls are to be blanked off. Critical barriers would be established within the inpatient rooms and a single stage entry shall be constructed leading into each room. A gurney must be able to roll through the decontamination area.
 - Windows are to be sealed at the edges with duct tape and all ventilation registers and openings into the room are to be sealed to limit airflow.
 - The entire unit is to be considered contaminated unless deemed otherwise by Infection Prevention.
 - Drinking and eating by staff shall be prohibited in patient care areas unless authorized by infection prevention.
- g. The establishment of the Smallpox or infectious disease unit will be done in three phases and are relative to the amount of disease in the community. If there is no disease in the community, only screening of patients, visitors and staff shall be performed. If there is disease in the community, but appears to be under control or very limited then only G&H1 and G&H2 will be used.
- Phase 1 - establishment of screening area on G&H-1 rear half. Establishment of the screening unit can be done fairly fast. This may be less than 8 hours. Many of the components are on site already and we do not need to rely on outside assistance. There is minimal disruption to the nursing units and research functions.
 - Phase 2 - establishment of treatment area on GH-1 front half. Establishment of G-1 treatment area to be used as a holding area and advanced treatment. This unit would be created as soon as we had the first positive case of disease in the local area. It can be established in 12 hours. Additional assistance would be needed for evacuating the research center, patients to other units or discharging them to home, and installing negative pressure containment's.
 - Phase 3 - establishment of treatment area on GH-2 entire floor. Establishment of GH-2 treatment area. This area would be established when we anticipate a significant chance of receiving patients that may need ICU level care.
 - This will take about 24 hours or more to establish. Patients would have to be evacuated to other units or facilities. Additional nursing and support staff would be needed as we are expanding the unit footprint by 100%. Establishment of negative pressure is more difficult on the second floor. We will need to rent a scissors lift hoist and have part of the concrete screening removed. This will require a heavy lift crane and welders.
- h. Move Plan: (This plan to be modified as the situation warrants)
- ATU to move to B-1.
 - GCRC outpatients may be seen in existing outpatient clinics. Inpatients are to be distributed to inpatient care units.
 - G-2 patients are to be integrated with other medical beds at SHC.
 - H-2 may need to be shut down and patients transferred to another facility that can continue their care.
 - The space-planning department will coordinate identifying temporary office space for displaced offices. These may include offices in the School of Medicine or on Welch Rd.
 - Design and Construction will assist in coordinating moves. If moves can not be coordinated, it may be necessary to the sealed the offices and protect the contents until the moves can be instituted at a later time.
- i. External set-up

- Perimeter- a temporary chain link fence would be placed between the south side of G-1 and the planted area. This is to limit visual and physical access to the windows and the ventilation equipment of the unit.
- Signs - Signage would be needed to guide patients to the screening area and to warn patients with certain symptoms as to where they need to go for care.
- Signage would also be needed on the security/perimeter fence for persons to stay back. And “Do not enter”.
- Security - Security would have to issue special ID badges to those workers that are authorized to work on the Unit. Criteria to be established.
- Screening Area
- Outfitted like a triage area with a desk chairs dynamap, thermometer and phone. Seating capacity should be about 20 persons.

j. Logistics

- Equipment - It is thought that only severely ill patients will be housed on this unit. They may need the essentials of an ICU including ventilators, code carts, monitors suction apparatus, beds and other monitoring equipment must be collected and taken to the unit. The departing unit will use most of the equipment that is already there.
- Linen - Disposable linen is to be used as much as possible and the linen is to be managed appropriately for the suspected agent. The linen chute is to be sealed and no linen may be placed into it.
- Biohazardous waste - All trash generated within the containment unit is to be considered Biohazardous waste. Biohazardous materials are to be treated before they leave the Stanford Site. This may include chemical sterilization, steam sterilization, or incineration depending on which method is available. It is not desired to bring biohazardous waste into the hospital for treatment; rather it is to be treated on the unit or at a site external to the hospital. Two rooms shall be set aside near the exit as a biohazardous waste storage area. Some wastes may be treated prior to removal from the unit.
- Pneumatic Tube. The pneumatic tube system is to be sealed to prevent transfer of air between
- Trash – All trash generated within the containment unit is to be considered Biohazardous waste. The definition of biohazardous waste in the screening unit is the same as for the rest of SUMC.
- Supplies – As much as possible disposable supplies and equipment are to be used. These items are not to be brought back into the hospital without credible evidence that they can not harbor or spread any of the infectious agents in question.
- Sewage – Normal sewage is to be maintained. No special processes or procedures are needed here unless warranted by the public health authorities.
- Staff are to shower upon exiting the unit in the male and female locker rooms located in HH100 and HH101.

k. Safety

- All health and safety procedures and plans shall remain in effect. It is understood that this unit is a special response
- Personal Protective Equipment - The following PPE is available.
 - Tyvek suits with boots and hoods
 - N95 mask
 - Full-face respirator with HEPA filtration cartridges.
 - PAPR with HEPA filters and a fully enclosed hood.

l. Infection Prevention Issues: To be determined depending on the suspected agent and disease. Follow the Infection prevention manual.

m. Hospital Emergency Operations Center

- The Main HEOC would be established in H3210. Additional space for local government authorities can be established in the Bing Dining Room or in the LPCH Board Room
- Media Briefings may be done in the Friedenrich Auditorium at LPCH

E. Event Recovery

1. Terminal Cleaning of equipment and facilities

Cleaning of facilities will be coordinated by Infection Prevention and Housekeeping. If cleaning is not possible decontamination and demolition will be coordinated by Design and Construction.

2. Staff support

Psychological support may be needed for staff after the event. Human Resources shall coordinate such services for staff as needed. Human Resources shall establish a plan to address workers related issues.

3. Business Recovery - Business Recovery shall be coordinated by the COO and involve the overall task of returning operations to the condition they were prior to the event. These activities will include finance, marketing, Medical Staff, Government Relations, and General Services. A needs assessment should be made of what the immediate and long range issues are and then an action plan created.

[If adapting this plan for use, insert Unit Floor Plan here and identify locations on Unit as necessary.]

<i>This policy applies to:</i> <input type="checkbox"/> Stanford Hospital and Clinics <input type="checkbox"/> Lucile Packard Children's Hospital	Date Written or Last Revision: 7-Aug-06
Name of Policy: Mass Fatality Plan <i>Final</i> ²	<p style="text-align: center;">Page 1 of 8</p>
Departments Affected: Environmental Health and Safety, Pathology, Security Services	

PURPOSE

The purpose of this policy is to outline the care and disposition of large numbers of human remains from Stanford Hospital and Clinics and Lucile Packard Children's Hospital

POLICY STATEMENT

This policy is guidance in the disposition of large numbers of human remains from Stanford Hospital and Clinics and Lucile Packard Children's Hospital as a result of a natural disaster, epidemic, pandemic or other catastrophic event.

1. The coroner of Santa Clara County will be the lead agency in the management of human remains, unless the remains have been released as per the Coroner's protocols
2. All human remains will be treated with respect and professionalism
3. When death is the result of a disaster, the body does not pose a risk for infection
4. Every effort must be taken to identify the bodies. As a last resort, unidentified bodies should be placed in individual niches or trenches, which is a basic human right of the surviving family members
5. Mass cremation of bodies should never take place when this goes against the cultural and religious norms of the population
6. Victims should never be buried in common graves

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May 2008

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PLAN:

1. To prepare for the possibility of mass fatalities during influenza pandemic, SHC/LPCH must:
 - a. Reassess current capacity for refrigeration of deceased persons.
 - b. Current capacity in the Hospital Morgue is about 25 - 50 adult persons. Additional space can be obtained in the School of Medicine anatomy lab of about 100 persons. Temporary refrigeration or freezer units are the best solution.
2. Primary Morgue overflow will be into refrigerated mobile units such as trailers or ISO containers that are commercially available. Remains will be stored on the floor of each trailer. Maximum capacity is 25 remains per trailer.
3. Secondary Morgue I overflow shall be in a secure area where the remains can be covered in ice.
4. Last resort capacity involves temporary internment. Adjacent fields could be utilized for temporary internment. Coordination with and permission of Stanford University is mandatory. Internment would involve soil removal, body identification, labeling, sample/photo collection, and internment. Remains would be exhumed for reburial by local authorities.
5. Remains that are contaminated by a chemical, biological or radiological agent will not be decontaminated at the hospital.
6. Contaminated remains will be placed inside two body bags and marked with the appropriate warning label Chemical, biological or radiological and a description of the contaminate and the concentration.
7. Remains deemed contaminated will be stored separate from other remains.

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8. All remains unless otherwise noted are to be managed using standard precautions as outlined by the blood borne pathogen plan.
9. Determine the scope and volume and create a stockpile of supplies (e.g., body bags) needed to handle an increased number of deceased persons.
10. The following are materials that may be needed for the implementation of this chapter
 - a. Body bags (200)
 - b. Body shroud kits (500)
 - c. Patient triage tags or other identifier tags (1000)
 - d. DNA collection kits (1000)
 - e. Refrigerated trailers (1-5)
 - f. Refrigerated ISO containers (1-5)
 - g. Electrical hook-ups for trailer and containers (as needed)
 - h. Fork lift (1)
 - i. Back hoe tractor (1-2)

IV. Scaled Provisions

1. Small Scale Morgue Operations less than 50 bodies
 - a. Use regular facilities such as the cold room
 - b. Remove racks in room if necessary and stack on floor
 - c. Bodies are to be tagged and managed as per normal procedures
 - d. Security is to be the primary responsible department
 - e. Security should solicit help from other departments to expedite the removal of remains from the hospital to mortuaries or the coroner.
2. Medium Scale operations more than 50 bodies and less than 1000
 - a. Refrigerated trailers are to be obtained by Materials management
 - b. Trailers are to maintain temperature below 32 degrees F.
 - c. Trailers are to be stationed in a secure but close area to the hospital.
 - i. Examples are: Loading Dock, Fenced area of the Falk Parking Lot, or other similar area

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- d. Trailers will have 24 hour security
 - e. Bodies are to be placed within the trailer in body bags or similar container.
 - f. Bodies are to be tagged and managed as per normal procedures
 - g. Security is to be the primary responsible department
 - h. Security should solicit help from other departments to expedite the removal of remains from the hospital to mortuaries or the coroner.
 - i. Bodies are not to be stacked upon each other.
3. Large Scale Morgue Operations (Mass Burial)
- a. Identify the dead, record the identification or collect and record evidence such as DNA that may lead to later identification of the bodies that may have to be buried in an unidentified state.
 - b. Receive, label and impound property of the dead. Use the property as necessary for identification of the dead, and hold the property for the next of kin or the Public Administrator.
 - c. Keep records of names and numbers of dead. It is essential to maintain a postmortem board containing all known information regarding all remains or parts of remains that may be identifiable.
 - d. Receive telephone inquiries from or solicit relatives and friends of the dead or missing persons to assist in the identification. This function may be handled by American Red Cross personnel or volunteers who have been trained to provide relief for survivors in times of disaster. Members of the clergy within an area may provide assistance in dealing with relatives and friends, as well as assisting in notification of death.
 - e. File and record emergency death certificates.
 - f. Photograph, x-ray and chart teeth, determine the cause of death.
 - g. Release bodies to mortuaries or a transportation service for transport to burial sites.
 - h. Obtain all the necessary equipment, supplies and personnel to accomplish these tasks.

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V. Mass Burial Plan

1. To prepare for the possibility of mass fatalities during influenza pandemic, hospitals must:
 - a. Assess current capacity for refrigeration of deceased persons;
 - b. Review current disaster plan for managing remains and temporary morgue overflow;
 - c. Modify plans to address potential need to manage contaminated remains for days;
 - d. Determine the scope and volume and create a stockpile of supplies (e.g., body bags) needed to handle an increased number of deceased persons.
2. Mass burial may become necessary when the number of victims becomes a public health hazard and the dead cannot be:
 - a. Adequately refrigerated or embalmed to prevent decomposition.
 - b. Processed and identified.
 - c. Released to the next of kin.
 - d. Transported to and/or cared for by cemeteries, mausoleums, crematoriums, etc.
3. The decision to begin mass burial must be made by the Coroner and County Health Officer in conjunction with the State Department of Health Services. Coordination also should be achieved with State OES, the County Emergency Operations Center, campus officials, city officials and religious leaders within the community.
4. The site of mass burial also must be agreed upon by the above agencies, taking into consideration the number and location of dead to be buried. Ideally, an existing cemetery would be the most logical location of mass burial. However, that may not be possible because of the numbers to be buried and the area available, its proximity to the disaster site and the damage the cemetery received during the disaster. The next consideration should be given to federal-, state-, county- or city-owned property or rights-of-way, such as:
 - a. Parks and recreational areas;
 - b. Flood control basins (weather permitting);
 - c. Sides of freeways;
 - d. Areas beneath high power lines.

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5. The final consideration should be given to privately owned property (except cemeteries), preferably large open fields such as are found in industrial or agricultural areas, etc.
6. Access and egress also are important factors, along with the type of terrain and the need to facilitate later exhumations.
7. These exhumations will be ordered to attempt to identify unknown bodies and for the re-interment of those identified by the next of kin in the cemetery of their choice. Bodies remaining unidentified must still be re-interred in a designated cemetery.
8. Those bodies designated for mass burial should be processed to ensure that:
 - a. Body has been rechecked for any type of jewelry or other item that may assist in identification.
 - b. Postmortem information has been properly documented, especially scars, tattoos, deformities and other physical descriptions.
 - c. Fingerprints have been taken; if not, fingers should be rechecked and prints taken if possible.
 - d. Mandible and maxillary have been removed and placed into a properly marked container.
 - e. DNA samples obtained
 - f. An additional body tag has been attached, properly filled out and placed into a small, sealed plastic bag.
 - g. If remains are not arterially embalmed, the body has been wrapped in celu-cotton or other absorbent material.
 - h. Embalming fluid (2 to 3 gallons cavity fluid or 10% formalin) has been poured over remains.
 - i. Body has been wrapped in plastic sheeting or disaster pouch and tied/zipped to prevent leakage.
 - j. A tag has been attached to the pouch containing the body.
 - k. If possible, body has been placed in a wooden or metal container for burial; that container has been marked (spray painted) with corresponding identification numbers.

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1. Exact location of each body buried must be recorded on grid maps, including dates, times and other information necessary for exhumations at a later time. Each burial site also must be marked (staked) with the correct corresponding identification numbers.

VI. Counseling Service

An information and/or counseling service staffed by American Red Cross workers, mental health workers, clergy and others experienced in Coroner activities should be established for relatives and friends of missing or deceased persons.

VII. RELATED SHC / LPCH DOCUMENTS

- A. Disaster Plan Manual (Action Guide)
- B. Emergency Management Plan
- C. Pandemic Influenza Response Plan
- D. Disaster Plan Manual (Text Version)
- E. Emergency Guidelines – Inpatient Facilities
- D. Emergency Guidelines – Outpatient Facilities

VIII. DOCUMENT INFORMATION

- A. Document Author – Per Schenck: New Policy 7/07
- B. Owner – Office of Service Continuity and Disaster Planning (OSCDP)
- C. Distribution and Training Requirements – This policy resides in the Pandemic Flu Plan, and in the General Disaster Plan.

<p><i>This policy applies to:</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Stanford Hospital and Clinics <input type="checkbox"/> Lucile Packard Children's Hospital 	<p>Date Written or Last Revision:</p> <p>7-Aug-06</p>
<p>Name of Policy: Mass Fatality Plan <u>Final</u></p>	<p>Page 8 of 8</p>
<p>Departments Affected: Environmental Health and Safety, Pathology, Security Services</p>	

- D.** Review and Renewal Requirements – The plan is reviewed annually by the EC Committee, the Disaster Committee, and the Infection Control Committee(s).
- E.** Approvals – EoC Safety Committee Aug 2007, Disaster Committee Aug 2007
- F.** Review & Revision History